Georgia Department of Community Health

SXC Health Solutions, Inc.

Atypical Antipsychotic Prior Authorization Form

Fee-for-Service Medicaid/PeachCare for Kids
PHONE #: 866-525-5827
FAX #: 888-491-9742

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed. **(One form per member please)**

Member's ID#:_____

Member's Full Name: _____ **Member's Date of Birth**___/___/_____

Medication Requested:_____**Strength:**_____

Directions: _____**Dosage Form:** _____**Compound** ☐ **Y** ☐ **N**

Physician's Name: _____ **Physician's NPI:**_____

Physician's Address:_____ _

Physician's Phone: _____**Physician's Fax:** _____

What is the member's diagnosis?

☐ Bipolar disorder ☐ Schizophrenia ☐ Schizoaffective Disorder
☐ Major Depressive Disorder ☐ Other (specify): _____

****NOTE: Section A or B must be completed.****

CHECK ONE A *OR* B

☐ A. The member has been established on the requested medication

1. How long has the member been taking the requested medication?

   ☐ < 14 days ☐ ≥14 days

2. Has the member shown improvement in symptoms while on the requested medication?
   ☐ Yes ☐ No
   If yes, please check one or more boxes below for areas of improvement: ___

☐ delusions	☐ excitement	☐ conceptual disorganization
☐ grandiosity	☐ hostility	☐ hallucinatory behavior
☐ suspiciousness/persecution	☐ blunted affect	☐ emotional withdrawal
☐ passive/apathetic social withdrawal		☐ poor rapport
☐ difficulty in abstract thinking	☐ lack of spontaneity and flow of conversation	
☐ stereotyped thinking	☐ suicidal thoughts	☐ depressive symptoms
☐ other_____		

☐ B. The member has never taken the requested medication

1. Does the member have an immediate family member (father, mother, brother or sister) who has been successfully treated on the same drug requested?
   ☐ Yes ☐ No ☐ Cannot Disclose
2. Which preferred medication(s) has the member tried? (check all that apply)
   ☐ Geodon Dates: _____ ☐ Invega Dates: _____

☐ Risperdal Dates: _____ ☐ Seroquel Dates: _____ ☐ None

3. Reason preferred agents are not appropriate for this member: (Complete for each drug in the following table)

Drug	Reason inappropriate choice for member
Rispderdal	
Invega	
Seroquel	
Geodon	

4. For Abilify (adjunctive therapy for major depressive disorder only): Reason antidepressant monotherapy is not adequate for this member: (Complete for each drug/class in the following table)

Drug	Reason antidepressant monotherapy is inadequate
Cymbalta (duloxetine)	
Effexor (venlafaxine)	
SSRIs (citalopram [Celexa], escitalopram [Lexapro], fluoxetine [Prozac], fluvoxamine [Luvox], paroxetine [Paxil], or sertraline [Zoloft])	

CHECK IF APPLICABLE

☐ **C. An orally disintegrating dosage formulation is being requested.**

1. What prevents the member from taking the regular oral dosage form?
   ☐ Dysphagia ☐ Compliance monitoring required
   ☐ Other (specify):_____

☐ **D. Risperdal Consta is being requested.**

1. Has the member tried oral risperidone or been noncompliant after a trial of oral risperidone? ☐ Yes
   Date of last therapy: _____ ☐ No

2. Is the prescribing physician a psychiatrist or has a psychiatrist been consulted?
   ☐ Yes ☐ No

3. If Risperdal Consta, where will the medication be administered?
   ☐ Home health
   ☐ CSB (Community Service Board health center)
   ☐ Outpatient clinic or physician's office**
   ☐ Other (specify):_____

** If you are requesting for authorization for administration in a physician's office or outpatient clinic other than a CSB, please go to the Registered User portion of the Georgia Health Partnership website at www.ghp.georgia.gov to request a PA from Physician Services.

Physician Signature: _____

Contact Person:_____ **Phone:**_____

SXC Health Solutions, Inc. will provide a response within 1 business day upon receipt.